IMPROVING THE PROVIDER ENROLLMENT PROCESS

A Certified Public Manager Project

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February 2017

South Carolina Department of Health and Human Services

Monitoring Provider Enrollment

Introduction

The mission of the South Carolina Department of Health and Human Services (SCDHHS) is to "purchase the most health for those in need at the least cost to taxpayers". SCDHHS manages the Medicaid program within the state of South Carolina, to provide healthcare services to those in need due to low income. Medicaid is South Carolina's grant-in-aid program by which the Federal and state governments share the cost that provides health coverage to certain categories of low-asset people, including children, pregnant women, parents of eligible children, individuals with disabilities and elderly needing nursing home care. As a result of this grant in aid program, "(Medicaid) pays for some or all of their medical bills."

SCDHHS is committed to the health and well-being of these citizens by promoting quality of life and improvement of the health care being provided by the Medicaid health plans, and the health care providers with whom they partner. These variables are monitored by reporting on the performance of individual health plans serving South Carolina Medicaid recipients in a managed care organization (MCO), through medical home networks (MHN), and fee-for-service (FFS) providers.

Centers for Medicare & Medicaid Services (CMS) have developed new regulations that are in effect under the Affordable Care Act (ACA) to strengthen State Medicaid agencies (SMAs) requirements to enroll in the fee-for-service (FFS) Medicaid and Children's Health Insurance Programs (CHIP). The ACA was passed by Congress on March 23, 2010. The law requires that all providers of medical, other items or services and supplies meet Federal requirements. The final determination to support the health law was approved on June 28, 2012 by the Supreme Court. On April 27, 2012 Medicare and Medicaid Programs finalized changes in the Provider and

Suppliers Enrollment, Ordering and Referring and documentation requirements in Provider agreements.

Over the last several years, SCDHHS has improved and expanded eligibility through Federal mandates to overhaul the Medicaid enrollment process and is actively working to enroll people who are eligible based on the existing guidelines in place today. There are now additional employees in the state's Medicaid call center, an online application process, and SCDHHS is using databases of people who already qualify for other income-based programs like Children Health Insurance program (CHIP) to help identify residents of South Carolina who are eligible for Medicaid. This only serves to benefit the integrity of the Medicaid process and to assist those in our state who are in the greatest need. When state employees answer their phones with the greeting, "It's a great day in South Carolina, how can I help you?" it reminds "us" that we work for the taxpayers and it sends out a positive message that we are here to help.

The Program

On August 1, 2012 South Carolina's State Medicaid agency (SMA), SCDHHS, initiated the implementation of the new guidelines from the federal government regarding regulated screening and new enrollment requirements. Changes made under the ACA mandates SMAs to require all providers, ordering and/or referring physicians under the state plans, to be enroll into the programs. SMAs require that all providers with an exception of individual practitioners to disclose information about ownership, control, and management of provider. SMAs are required to obtain disclosure information, obtain a signature on provider agreement and to check eligibility against Federal databases based on the categorical risk level of fraud. SMAs may deny an enrollment that has not been disclosed, verified or provider does not pass screening requirements.

SMAs revalidate providers every five (5) years after the initial enrollment, which would consist of the same screening process.

Provider enrollment is based on risk categories (limited, moderate, and high). Risk levels are determined by a provider's risk of fraud, waste, and abuse. Moderate and high-risk providers will undergo a pre and post on-site visit. Moderate and high-risk must meet all requirements for limited-risk categories while providing additional information. The purpose of the visit is to verify information that was submitted to the SMA. While on-site visits are required for moderate and high-risk an unannounced site visit to enrolled provider may be performed. A high-risk provider as well as all individuals with five percent (5%) or more ownership will conduct fingerprint-based criminal background checks using Federal and State databases.

The new regulations require SMAs to obtain from any Medicaid provider, information on any person on their staff who has access to an individual's Medicaid account through a Disclosure of Ownership document. Disclosures must be made upon submission of application, when signing the provider agreement and when SMAs request information for revalidations. Any change in ownership must be revealed within thirty-five (35) days of the change taking place. The information that has to be disclosed through the Disclosure of Ownership document is the individual's name, address, date of birth and social security number. Family relationships between the person with ownership or control, and all individuals with five percent (5%) or more ownership in the provider or certain subcontractors must also be provided to the SMA through this document. Failure to properly reveal ownership information is subject to mandatory termination of the Provider's Medicaid contract.

There is an application fee for some specific physicians enrolling in South Carolina Medicaid, those adding a practice location and those revalidating enrollment. The fee is currently

five hundred and sixty dollars ($560), up from five hundred fifty-four ($554) in 2016. The cost is to offset the costs of screenings. The fee does not apply to individual physicians, non-physician practitioners, medical clinics or group practices. Individual physicians or not-physician practitioners are not required to pay this fee. If a provider is currently enrolled in Medicare or Medicaid in another state, he or she will not have to pay another enrollment fee and will not be required to go through the entire enrollment and screenings process again. The acting SMA will contact the previous state to verify enrollment information provided to the state.

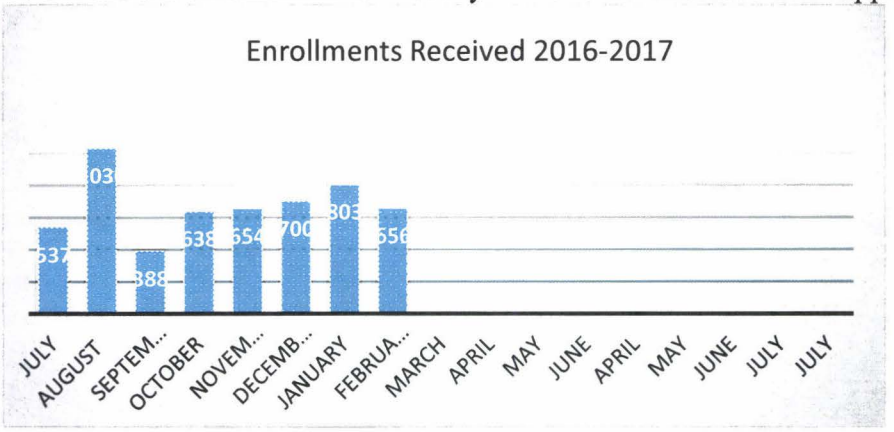
The types of providers that may enroll in the FFS Medicare/Medicaid agreement are as follows:

- **Atypical Provider-** These providers do not provide health care (home or vehicle modifications) Atypical providers cannot receive a National Provider Identifier (NPI)
- **Atypical Individual Provider-** provides non-health related services to health care members (may bill independently or services may have an affiliation with an organization). NPI is not required
- **Atypical Organization Provider-** a facility, agency, provider may or may not be eligible for an NPI and NPI is not required
- **Individual Provider-** a person enrolled directly who provides health services to health care members. An individual may bill independently for services or may have an affiliation with an organization.
- **Individual/Sole Proprietor Provider-** a provider enrolled directly who provides health services go health care members. An individual may bill independently for services or may have an affiliation with organization.

- **Ordering/Referring Provider-** all providers of health care services may be ordering /referring providers but not all ordering /referring providers are billing providers.
- **Organization-** Any entity, agency, facility or institution that provides health services

The Problematic Process

As part of the current program, a SMA provides day-to-day oversight on contract management, contract deliverables and contractor activities through a checks and balances system (handled by an assigned Grants Administrator) to ensure quality of service delivery. The Medicaid Claims Control Services (MCCS) contract is a contract between a SMA, in this case SCDHHS, and a contracted company. This MCCS contract states that the contractor must meet one hundred percent (100%) accuracy and timeliness when processing the Provider enrollment functions. This contract also states that the contractor has up to thirty (30) days to process all enrollments as well as revalidations and reactivations. In a broad definition, the Grants Administrator's responsibility is to, on a monthly basis, track all provider enrollment statuses and ensure that the requirements for the contract between each provider and SCDHHS are being met. Below are the enrollments for fiscal year 2016-17 that have been approved.



The following tasks were identified as the current operational process for the SCDHHS Grants Administrator in regard to the MCCS contract with Blue Cross Blue Shield of South Carolina (BCBS):

Deliverable
Verify contractor reviewed and validated the information contained within the provider applications and then reenroll qualified applicants in the MMIS
Verify that the Provider, all affiliated Providers and affiliated organizations have been screened in the nations wide database.
Verify application fee was paid through sc.gov.
Verify Disclosure of Ownership.
Conduct license verification
Verify comprehensive validation of Provider credentials.
Verify Exclusion Database System MEDS checks.
Verify risk category.
Verify payment of any required application through SC.gov
Verify pre and post Provider site visits.
BCBS must track Disclosure of Ownership information for each new Provider applicant.
BCBS must perform thirty (30) day checks of Legacy data.
Verify enrollment
Verify each enrollment or update produces TADs (turn around documents)
BCBS must generate information request, correspondence or notifications based on the status of the application for enrollment.
Verify Provider updates where keyed within 10 business days from date of receipt of the information.
Verify enrollments are keyed and processed within 30 business days from date of receipt.
Verify payment of enrollment fees to Medicare, other states by utilizing Provider Enrollment, Chain, and Ownership Systems (PECOS).

Verify that contractor has updated/completed special enrollment projects as directed by SCDHHS • Annual Provider file maintenance • Massive updates to files • Large mail-outs to Providers
Verify annual Provider revalidation Reviews.
Verify that the contractor assigned and maintained Provider numbers for Providers not eligible for an NPI number.
Verify that BCBS has enter rate data provided by SCDHHS for each Provider rate and fiscal year-end change within 10 business days of receipt or for large updates the agreed upon dates established by SCDHHS.
Medicare Exclusion Database System MEDS checks.
Verify that contractor completed appropriate verification for licensure and certification; CMS exclusion; electronic media claims (EMC); trading partner agreements; CLIA and W-9s according to SCDHHS policies and procedures
BCBS must prepare, maintain and provide Evaluation of Contractor Functions for the following: • Training modules, including number in attendance will be maintained as determined by SCDHHS • 90% of the class evaluations must be positive as determined by SCDHHS • 90% of the trainer evaluations must be positive as determined by SCDHHS.

The MCCS contract with BCBS was used in researching a process improvement need. This current contract consists of eighty (83) deliverables that have daily, monthly, quarterly and annual assigned times of expected delivery. The Provider Enrollment section of this contract is very detailed with an enormous amount of information to verify. It is the most extensive and most time-consuming section of the contract. Because this section is so specialized there are no definitive guidelines or "core pieces" on how to most efficiently complete this area of the audit. The resources used to monitor Provider Enrollments are two (2) systems, I-Flow - where the Provider Enrollment data is stored and the Medicaid Management Information Systems (MMIS) - where

the Medicaid data is stored. Both of these systems require a separate and time-consuming "look-up" for all information being reviewed. Other resources in monitoring Provider Enrollments include a Julian calendar, a Medicaid crosswalk table and a county code list.

The BCBS management team perform a Quality Assessment (QA) through the checking and rechecking of specific duties completed by the BCBS staff members. This QA is assessed at one hundred percent (100%). An average of six hundred seventy-eight (678) enrollments are received a month. The SCDHHS Grants Administrator QAs only a random sample of the providers enrolled, averaging 250 - 275 enrollments per month. BCBS and SCDHHS meet once a month to discuss various findings of non-compliance. Errors that have been reported by both the BCBS staff members and by the SCDHHS Grants Administrator prove to be beneficial in holding the area of provider enrollment accountable and in contributing to the overall integrity of the program. However, review of one enrollment, utilizing the current process and tools provided, has proven to be extremely tedious and time consuming. This review process consists of logging into I-Flow and MMIS. Once logged into I-Flow the QA sample tab will give you an enrollment number. In the Image Viewer screen in I-Flow the enrollment number is keyed in and generates the online enrollment. From the enrollment the provider ID number is identified and keyed into MMIS (F4) to verify provider's name and physical and payment address, contact number, social security number and license number. From I-Flow identify the risk category from the notes tab and verify the risk with the Medicaid cross walk. In I-Flow verify that Disclosure of Ownership from the provider and affiliated providers have been provided. The banking information is located under the supporting documents tab in I-Flow and is verified in MMIS (F16). Next, return to I-Flow under the supporting tab to determine if a Clinical Laboratory Improvement Amendments (CLIA) is required and have been updated and verified in MMIS (F2). The county code is provided on the enrollment and is keyed into MMIS and verified from the county code list. Next, the provider or practice specialty code is located in I-Flow and is verified in MMIS against the Medicaid

crosswalk. Then, verify the taxonomy code and NPI in MMIS (F9 and F20) against the provider's enrollment in I-Flow. Timeliness of the enrollment is determined by checking I-Flow (date enrollment was received and date approval summary was sent to provider). Finally, the effective date of enrollment is determined by going back 90 days using the, "90 Day Calculation for Enroll Date" calendar. This process can take up to an average of 30 minutes to complete. Monthly deadlines are set in place by SCDHHS Supervisors and the Grants Administrator can never truly "catch up" to the work that lay before them with processes like these that take so long to complete.

Process Improvement

In developing an improvement to the current process, meetings were set and I collaborated with the BCBS Provider Enrollment Management team to discuss what their current process entails and what, if any, data could be pulled in order to compile reports containing information from multiple areas that can be used to analyze the providers' enrollment information and thus help maximize the Grants Administrators efforts in monitoring this specific area of the provider contract.

Information gathered through these meetings include:

1. BCBS has put in place a system that shows all enrollments that are within fifteen (15) days of being received into the BCBS queue and have not yet been reviewed, accepted and completed.
2. These enrollments will populate at the top of BCBS staff's "to be processed" queue. These enrollments are researched, screened and processed by BCBS staff.

3. Once reviewed, a summary of the enrollment of these prioritized applications is then sent to the provider.
4. These prioritized enrollments are completed before the processing of any new provider enrollments.
5. Numerous parts of the BCBS findings and crosschecks can be pulled and downloaded into several different spreadsheets.

Once BCBS has completed their part of checks and balances, they send the Grants Administrator a monthly "Error Rate" report for the SCDHHS side of Provider enrollment to cross-check and monitoring. The report contains deliverables that they were able to provide in a report. The original process had to be looked up individually (see Appendix A). This "Error Report" will be the main report used by the SCDHHS Grants Administrator. It contains the most comprehensive and verifiable data.

In their process, BCBS also certifies that a QA review is completed at one hundred percent (100%) for timeliness and accuracy. This certification creates a "QA Review" report provided to SCDHHS. This report contains the information that has been grayed out on the Provider Enrollment Report (see Appendix B). In the original process, this information had to be cross checked manually per column. The Grants Administrator is then able to review a random sample of this report, and through cross-referencing is able to verify the BCBS findings were corrected after having been identified and reported.

Monitoring some of the sections will still be a manual process. However, the reports will help to eliminate a good deal of waste and will be most beneficial in verifying and maintaining contract adherence in the timeliest, effective and efficient way as we consciously improve this section.

Summary

SMAs imposed moratoria to help to better protect Medicaid from fraud, waste and abuse. The changes to Medicaid enrollment requirements helps to ensure that only qualified providers enroll. Providers with a fraudulent past are not qualified to enroll. The regulations of the screening for provider enrollment as well as revalidation screenings were designed to discourage fraudulent providers from enrolling in the programs. This process has helped to reduce improper payments while lowering costs and improving care. Improving the productivity and timeliness in the enrollment audit function by implementing the use of reports created by BCBS, in lieu of a provider by provider, section by section, manual cross-check, will prove not only to generate a more transparent work-flow, but to allow the Grants Administrator to feel empowered in their ability to complete the task that is at hand in this section of contract monitoring.

Appendix A – Provider Enrollment Spreadsheet

A	B	C	D	E	F	G	H	I	J	K	L	M	N	O	P	Q	R	S	T	U	V	W	X	Y	Z	AA	AB	AC
DCN	RISK CATEGORY	ENROLLMENT START DATE	ENROLLMENT COMPLETION DATE	UPDATES PROCESSED IN 10 DAYS	ENROLLMENTS PROCESSED WITHIN 30 DAYS	PRE AND POST SITE VISITS	PROVIDER ID NUMBER	AFFILIATED PROVIDERS	TADS	MCSIS	MED	SAM	PECOS	NPPES	LEIE/OIG	VALIDATE PROVIDER CREDENTIALS	LICENSE	OWNER & MANAGING RELATION-SHIPS	DISCLOSURE OF OWNERSHIP INFO	COUNTY CODES	LEGACY DATA	SC GOV PAYMENTS	PROVIDER MASSIVE UPDATES AND LARGE MAIL-OUTS	ENROLLMENT STATUS	CLIA	EVALUATIONS	PROVIDER RATES	PROVIDER NPI NUMBER
16313065000151	LIM	11/8/2016	12/9/2016	0	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	X	✓	✓	✓	✓	✓	✓	✓
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16328065000056	LIM	11/23/2016	12/29/2016	0	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	X	✓	✓	✓	✓	✓	✓	✓
16363065000108	LIM	12/28/2016	12/29/2016	0	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	X	✓	✓	✓	✓	✓	✓	✓
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16326065000151	DUP			0																								
16326065000120	LIM	11/21/2016	12/22/2016	0	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	X	✓	✓	✓	✓	✓	✓	✓
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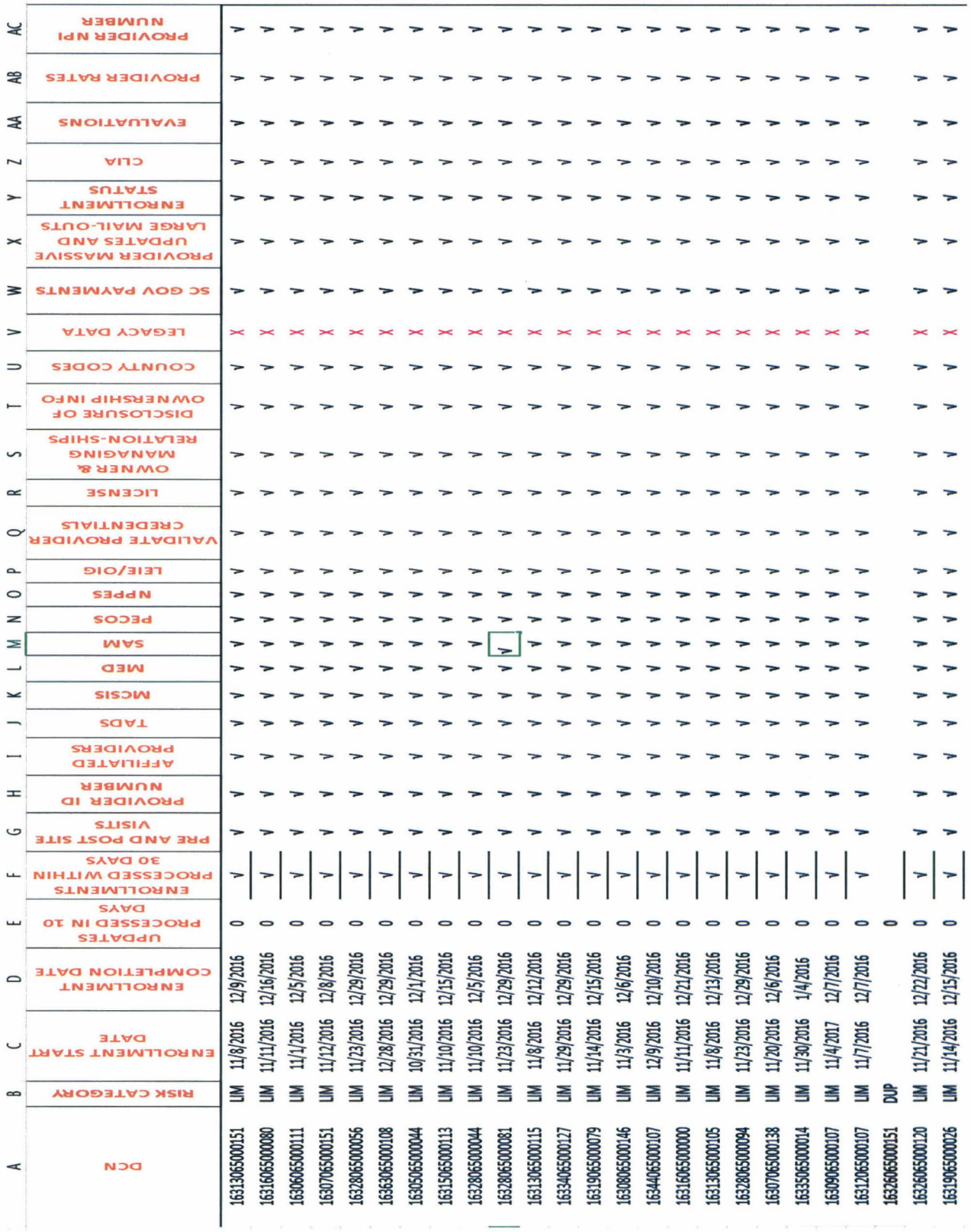
Appendix B – Provider Enrollment Spreadsheet



A	B	C	D	E	F	G	H	I	J	K	L	M	N	O	P	Q	R	S	T	U	V	W	X	Y	Z	AA	AB	AC
DCN	RISK CATEGORY	ENROLLMENT START DATE	ENROLLMENT COMPLETION DATE	UPDATES PROCESSED IN 10 DAYS	ENROLLMENTS PROCESSED WITHIN 30 DAYS	PRE AND POST SITE VISITS	PROVIDER ID NUMBER	AFFILIATED PROVIDERS	TADS	MCSIS	MED	SAM	PECOS	NPPES	LEIE/OIG	VALIDATE PROVIDER CREDENTIALS	LICENSE	OWNER & MANAGING RELATION-SHIPS	DISCLOSURE OF OWNERSHIP INFO	COUNTY CODES	LEGACY DATA	SC GOV PAYMENTS	PROVIDER MASSIVE UPDATES AND LARGE MAIL-OUTS	ENROLLMENT STATUS	CLIA	EVALUATIONS	PROVIDER RATES	PROVIDER NPI NUMBER
16313065000151	LIM	11/8/2016	12/9/2016	0	√	√	√	√	√	√	√	√	√	√	√	√	√	√	√	√	X	√	√	√	√	√	√	√
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16328065000081	LIM	11/23/2016	12/29/2016	0	√	√	√	√	√	√	√	√	√	√	√	√	√	√	√	√	X	√	√	√	√	√	√	√
16313065000115	LIM	11/8/2016	12/12/2016	0	√	√	√	√	√	√	√	√	√	√	√	√	√	√	√	√	X	√	√	√	√	√	√	√
16334065000127	LIM	11/29/2016	12/29/2016	0	√	√	√	√	√	√	√	√	√	√	√	√	√	√	√	√	X	√	√	√	√	√	√	√
16319065000079	LIM	11/14/2016	12/15/2016	0	√	√	√	√	√	√	√	√	√	√	√	√	√	√	√	√	X	√	√	√	√	√	√	√
16308065000146	LIM	11/3/2016	12/6/2016	0	√	√	√	√	√	√	√	√	√	√	√	√	√	√	√	√	X	√	√	√	√	√	√	√
16344065000107	LIM	12/9/2016	12/10/2016	0	√	√	√	√	√	√	√	√	√	√	√	√	√	√	√	√	X	√	√	√	√	√	√	√
16316065000000	LIM	11/11/2016	12/21/2016	0	√	√	√	√	√	√	√	√	√	√	√	√	√	√	√	√	X	√	√	√	√	√	√	√
16313065000105	LIM	11/8/2016	12/13/2016	0	√	√	√	√	√	√	√	√	√	√	√	√	√	√	√	√	X	√	√	√	√	√	√	√
16328065000094	LIM	11/23/2016	12/29/2016	0	√	√	√	√	√	√	√	√	√	√	√	√	√	√	√	√	X	√	√	√	√	√	√	√
16307065000138	LIM	11/20/2016	12/6/2016	0	√	√	√	√	√	√	√	√	√	√	√	√	√	√	√	√	X	√	√	√	√	√	√	√
16335065000014	LIM	11/30/2016	1/4/2016	0	√	√	√	√	√	√	√	√	√	√	√	√	√	√	√	√	X	√	√	√	√	√	√	√
16309065000107	LIM	11/4/2017	12/7/2016	0	√	√	√	√	√	√	√	√	√	√	√	√	√	√	√	√	X	√	√	√	√	√	√	√
16312065000107	LIM	11/7/2016	12/7/2016	0	√	√	√	√	√	√	√	√	√	√	√	√	√	√	√	√	X	√	√	√	√	√	√	√
16326065000151	DUP			0																								
16326065000120	LIM	11/21/2016	12/22/2016	0	√	√	√	√	√	√	√	√	√	√	√	√	√	√	√	√	X	√	√	√	√	√	√	√
16319065000026	LIM	11/14/2016	12/15/2016	0	√	√	√	√	√	√	√	√	√	√	√	√	√	√	√	√	X	√	√	√	√	√	√	√

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